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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GUI TING ZHAO** **aka GUI T. ZHAO** **aka MAGGIE ZHAO** **2266 Charger Drive** **San Jose, CA 95131** **Registered Nurse License No. 669079** Respondent.	Case No. 2013-649 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing.

2. On or about November 14, 2005, the Board of Registered Nursing issued Registered Nurse License Number 669079 to Gui Ting Zhao, aka Gui T. Zhao, aka Maggie Zhao ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs under the following laws. All section references are to the

Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTES AND REGULATIONS

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . ."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

. . .

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

STATEMENT OF FACTS

11. At all relevant times, Respondent was employed at Homewood Care Center ("HCC"), a skilled nursing facility in San Jose, California. Respondent was trained and understood HCC's procedures for emergencies and use of emergency equipment in the event that a patient displayed signs and/or symptoms of an obstructed airway.

12. Patient 1 was a 92 year-old male resident of HCC who was on comfort care. Prior to August 24, 2009, Respondent had cared for Patient 1 on several occasions and was aware that he was at high risk for aspiration due to his difficulties with swallowing.

13. On August 24, 2009, at approximately 5:20 to 5:30 p.m., a Certified Nurse Assistant ("CNA") called Respondent to Patient 1's room and reported that after she fed Patient 1 two (2) to three (3) teaspoons of pureed food he began coughing and "looked different." Respondent observed that Patient 1 was lying in bed with his head up, that his face and lips were pale and he had labored, slow and shallow breathing. Patient 1 was verbally non-responsive, but he opened and closed his eyes when spoken to.

14. Respondent opened and visually inspected Patient 1's mouth, and used an ungloved finger to perform a circular sweep of his mouth. She then took his vital signs and noted that he had low blood pressure (60/40), a slow pulse (32) and depressed respiratory rate (8 breaths per minute), with an oxygen saturation level of 60% on room air. Respondent did not then perform any procedures in an attempt to dislodge foreign material from his airway as she believed that Patient 1 was having a stroke or heart attack.

15. Respondent left Patient 1's room and asked for assistance from two Licensed Vocational Nurses ("LVN's). On her way back to Patient 1's room, she grabbed a suction machine. On re-entering his room, Respondent observed then that Patient 1 was not breathing and was unresponsive. Respondent did not use the suction machine nor did she direct staff to use the suction machine. An oxygen mask had been placed over Patient 1's nose and mouth. Respondent did not perform cardiopulmonary resuscitation ("CPR") nor did she instruct staff to start CPR.

16. Respondent returned to the nursing station, reviewed Patient 1's medical record and

confirmed that he had a DNR (do not resuscitate) order. She then called his physician and made telephone calls to his relative, leaving a voicemail message on her second call to Patient 1's son. It was not until 5:49 p.m., that Respondent called 911 for emergency assistance.

17. Respondent was at the nursing station when paramedics arrived at HCC at 5:50 p.m. The paramedics initiated CPR without success. At 6:09 p.m., Patient 1 was declared deceased.

18. The Santa Clara County Coroner determined that Patient 1's immediate cause of death was asphyxia due to aspiration of a food bolus.

19. In an interview with the San Jose Police Department, Respondent reported that she suctioned and administered oxygen to Patient 1. However, paramedics with the San Jose Fire Department reported that the suction machine was sitting on a nightstand, clean, with no tubes attached and it was unplugged. They also reported that the oxygen machine was found in the hallway, with a plastic cover over it.

20. Respondent was terminated from HCC on November 16, 2009, as a result of the incident involving Patient 1.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence – Failure to Recognize Signs/Symptoms of an Obstructed Airway)

21. Respondent is subject to disciplinary action for gross negligence and/or incompetence pursuant to Code section 2761, subdivision (a)(1), as defined in title 16, sections 1442 and 1443 of the California Code of Regulations in that she failed to recognize that Patient 1 presented with signs and symptoms of an obstructed airway on August 24, 2009. The facts in support of this cause for discipline are set forth above in 12 through 15.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence – Failure to Intervene)

22. Respondent is subject to disciplinary action for gross negligence and/or incompetence pursuant to Code section 2761, subdivision(a)(1), as defined in title 16, sections 1442 and 1443 of the California Code of Regulations in that she failed to appropriately intervene in the care and treatment of Patient 1, when he presented with signs/symptoms of an obstructed

airway. The facts in support of this cause for discipline are set forth above in 12 through 16.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence – Use of a Contraindicated Procedure)

23. Respondent is subject to disciplinary action for gross negligence and/or incompetence pursuant to Code section 2761, subdivision (a)(1), as defined in title 16, sections 1442 and 1443 of the California Code of Regulations in that when she observed that Patient 1 had signs and/or symptoms of an obstructed airway she performed a finger sweep of his mouth, a contraindicated procedure. The facts in support of this cause for discipline are set forth above in paragraphs 13 and 14.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence – Failure to Timely Call 911)

24. Respondent is subject to disciplinary action for gross negligence and/or incompetence pursuant to Code section 2761, subdivision (a)(1), as defined in title 16, sections 1442 and 1443 of the California Code of Regulations in that she failed to timely call 911 after observing that Patient 1 had signs and/or symptoms an obstructed airway. The facts in support of this cause for discipline are set forth above in paragraphs 13 through 16.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence – Failure To Direct Staff To Provide Emergency Care)

25. Respondent is subject to disciplinary action for gross negligence and/or incompetence pursuant to Code section 2761, subdivision (a)(1), as defined in title 16, sections 1442 and 1443 of the California Code of Regulations in that she failed to direct staff to provide resuscitative care to Patient 1 who displayed signs and symptoms of an obstructed airway. The facts in support of this cause for discipline are set forth above in paragraphs 15 and 16.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Follow HCC Protocols Regarding Obstructed Airway)

26. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Code section 2761, subdivision (a), in that on August 24, 2009, she failed to follow the policies

and procedures at HCC for responding to a patient with signs/symptoms of an obstructed airway. The facts in support of this cause for discipline are set forth above in paragraphs 11 through 17.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct—False Statements to San Jose Police Department)

27. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Code section 2761, subdivision (a), in that she gave false information to the San Jose Police Department in their investigation of the cause of Patient 1's death. The facts in support of this cause for discipline are set forth above in paragraph 19.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Department of Consumer Affairs issue a decision:

1. Revoking or suspending Registered Nurse License Number 669079, issued to Gui Ting Zhao, aka Gui T. Zhao, aka Maggie Zhao;

2. Ordering Gui Ting Zhao to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: FEBRUARY 21, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
State of California
Complainant